STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185144	A. BUILDING _____ B. WING _____	C 08/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD NURSING CENTER	1608 VERSAILLES ROAD LEXINGTON, KY 40504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey investigating ARO #KY00015200 and ARO #KY00015019 was conducted on 08/18/10. Both AROs were unsubstantiated. However, deficient practice was identified at 483.13 Resident Behavior and Facility Practice.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by Homestead Nursing Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225	1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice: A) Resident #2 allegation was reported to the OIG office on 8-2-10. B) Interview able residents on the same "Assignment" as Resident #1 were interviewed, by Administration on August 19th, 2010, with no additional information found. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: A) All residents had the potential to be affected by this alleged deficient practice. B) An audit of personnel files was conducted by administration on August the 3rd and 4th, 2010. Issues were reported to the corporate office with follow up by general counsel on August 9th, 2010.	9/24/10

RECEIVED
SEP 24 2010
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Vicki Trump Administrator 9-21-2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185144	A. BUILDING _____ B. WING _____	C 08/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD NURSING CENTER	1608 VERSAILLES ROAD LEXINGTON, KY 40504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure an allegation of abuse was immediately reported to the State Agency, for one (1) of five (5) sampled residents (Resident #2). In a separate abuse allegation, the facility failed to conduct a thorough investigation, and failed to protect Resident #1 and other potential victims, during their investigation. as their investigation did not include other staff. The findings include: 1. Review of the clinical record revealed Resident #2 was admitted on 11/25/05 with diagnoses which included Alzheimer's Disease, Anxiety and Depression. Review of the facility's Investigation Summary, dated 08/04/10 revealed Resident #2 was the victim of an alleged abuse incident which occurred on 07/31/10. However, review of the State Agency's intake form revealed the facility did not report the allegation until 08/02/10. Interview with the Administrator on 08/18/10 at 10:50 AM revealed she did not call the State Agency on the weekend because she knew the office was closed. She stated she did not send an e-mail or fax because she did not want that kind of information "out and about."	F 225	C) Reportable events for the past 60 days were reviewed for compliance on August 19th, 2010 with no further issues found. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: A) The Social Worker is scheduled to attend a seminar on "Conducting Serious Incident Investigations" on September 23,2010. B) The District Director of Operations reviewed with the Administrator the facility policy including, but not limited to the seven components as it relates to tag F225. This was completed on August 18, 2010. C) All allegations will be reported immediately to the OIG office. If after hours a fax and/or e-mail will be sent, with a follow-up call on the next business day. 4) Indicate how the facility plans to monitor its performance to ensure that solutions are sustained: A) All reportable incidents will be reviewed by the QA nurse, within 24 hours after incidents, for 60 days for compliance with the seven components of the abuse policy. If no	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185144	A. BUILDING _____ B. WING _____	C 08/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD NURSING CENTER	1608 VERSAILLES ROAD LEXINGTON, KY 40504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 2 2. Clinical record review revealed Resident #1 was admitted on 01/19/10 with diagnoses which included Hypertension and Osteoarthritis. Review of the facility's Resident Abuse Investigation Report Form, dated 06/22/10, revealed Resident #1 was the victim of alleged physical abuse which occurred on 06/16/10. Continued review of the facility's investigation revealed the investigation did not include any interviews of other residents who might have been victims as well. In addition, no staff other than the alleged perpetrator were interviewed. Interview with the Social Worker, who completed the Investigation Report Form, on 08/18/10 at 10:00 AM, revealed she had no additional notes or interviews related to the incident. Interview with the Administrator on 08/18/10 at 4:30 PM revealed the investigation should have included interviews with other potential victims and staff. She stated the investigation process had been changed to include those additional interviews.	F 225	issues are found, incidents will be reviewed weekly in the Standards of Care Committee. The Standards of Care Committee consists of (but not limited to) the QA nurse, Administrator , Social Services, DON, Infection Control Nurse, Hsk Supervisor, Director of Medical Records, House Supervisor and Charge Nurses. B) Social Services will submit a summary log to the monthly QA committee. The summary log will include the seven components of the abuse policy (screening, training, prevention, identification, investigation, protection, reporting/ response). The QA Committee consists of (but not limited to) the Administrator, DON, Medical Director, QA Nurse, Infection Control Nurse, Dietary Manager, Pharmacist, Therapy, Social Services, Activities and Director of Medical Records.	